STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E281	A. BUILDING 01 B. WING	04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSPORT NURSING HOME	27 S SEVENTH ST GOSPORT, IN47433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 4/18/11 Facility Number: 000409 Provider Number: 155E281 AIM Number: 100291270 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Gosport Nursing Home was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 74 and had a census of 47 at the time of this survey.	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 1 doors to resident room #111 would latch into its frame. This deficient practice could affect 2 residents in the room as well as visitors and staff. Findings include: Based on observation on 04/18/11 at 11:00 a.m. with the Maintenance Supervisor the door leading into resident room number 111 on northwest hall did not latch into its frame. Based on interview on 04/18/11 concurrent with the observation with the Maintenance	K0018	The corrective action accomplished for this deficency is that the door was realigned to close into the door latch by maintenance.Those residents identified as having the potential to be affected by the deficient practice would be all residents in the facility.Measures put into place to ensure the deficient practice does not recur includes weekly observations by maintenance with maintenance fixing what needs to be fixed.Corrective action to be monitored by maintence supervisor.	04/21/2011

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	Supervisor it was acknowledged the entry door into resident room number 111 would not latch into its frame. 3.1-19(b)			
K0027 SS=E	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 3 sets of smoke barrier doors were maintained to minimize the gap between the doors when they were in the closed position. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 41 residents on northwest hall as well as staff and visitors. Findings include: Based on observations on 04/18/11 at 10:30 a.m. with the Maintenance Supervisor, the smoke barrier doors on northwest hall which swung in the same direction, were equipped with an astragal and a coordinator, however, the	K0027	The corrective accomplishment achieved for this deficiency is that the old coodinators were replaced with new heavy duty ones.Those residents found to have the potential to be affected by the deficient practice are all residents of the facility.Measures put into place to ensure the deficiency does not recur include monitoring of the coordinators during times of fire drills and testing of the system by the maintenance supervisor and personel in charge at the times of testing.Administrator to monitor results of fire drills.	05/06/2011

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	coordinator which was not screwed tight against the metal header interfered with the door with the astragal closing first. Based on interview on 04/18/11 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned set of smoke doors which swung in the same direction would not close completely because an improperly maintained coordinator prohibited the door with the astragal to close first. 3.1-19(b)			
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview, the facility failed to ensure exit access discharge was arranged so 1 of 8 exits were readily accessible at all times. LSC Section 7.1.6.2 requires abrupt changes in elevation of walking surfaces shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch, shall be beveled 1 to 2. This deficient practice could affect 5 residents on southeast hall as well as visitors and staff if the facility were required to evacuate. Findings include: Based on observation on 04/18/11 at 1:40	K0038	(1) The 150 foot walk way is NOT the designated evacuation route to a public way. The designated route is a straight black top of 65 feet to a public way.(2) Door knob was changed to a passage knob, To be monitored by the maintenance supervisor.Addendum: The fence was removed so that a direct exit is maintained to a public way. The blacktop is provided without obstruction which is 10 feet wide and 65 feet long. Emergency lighting is present. To be monitored by the administrator. Corrected 5/24/11.	05/24/2011

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	p.m. with the Maintenance Supervisor, the exit discharge, made of asphalt, leading out of southeast hall toward southwest hall exit, a one hundred and fifty foot distance, had a walking surface which was buckled and uneven exceeding a one half inch elevation. Based on interview on 04/18/11 concurrent with the observation with the Maintenance Supervisor it was acknowledged the aforementioned exit discharge for southeast hall was buckled in several areas which would not provide a nominally level surface to walk on to reach a public way. 3.1-19(b) 2. Based on observation and interview, the facility failed to provide 1 of 47 resident entry doors with door knobs which could not be locked. This deficient practice could affect 2 residents in room #103 as well as visitors and staff if the occupants were required to exit the room. Findings include: Based on observation on 04/18/11 at 12:10 p.m. with the Maintenance Supervisor, room number 103 had a locking door knob with the locking switch on the corridor side of the door which if in the locked position could prevent the occupants from evacuating the room.			

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	Based on interview on 04/18/11 at 12:12 p.m. it was acknowledged by the Maintenance Supervisor there was a door knob with a lock on the corridor side of the door which could trap the occupants in the room if the knob was locked. 3/1-19(b)			
K0046 SS=E	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. 1. Based on observation and interview, the facility failed to ensure 1 of 8 exits was provided with emergency powered illumination. LSC 7.9.1 says the exit discharge shall include only designated stairs, aisles, walkways leading to a public way. LSC 7-9.2 requires emergency lighting shall be provided for not less than 1 1/2 hours arranged to provide not less than an average of 1 foot candle,and not less than 0.1 foot candles, measured along the path of egress at floor level. This deficient practice could affect 5 residents evacuating the facility from southeast hall as well as visitors and staff. Findings include: Based on observation on 4/18/11 at 11:39 a.m. with the Maintenance Supervisor, the exit discharge for southeast hall traversing one hundred and fifty feet of walk to a public way was not provided with exterior	K0046	The courtyard sidewalk is NOT designated as a way of evacuation to a public way. Public exit is a straight 65 foot exit to a county road.The complete defective light and battery pack was replaced. Measures put into place to ensure the corrective action does not recur is weekly observation by the maintenance supervisor with documentation of findings.Corrective action to be monitored by maintenance supervisor and administrator. Addendum: The fence was removed so that a direct exit is maintained to a public way. Blacktop is provided without obstruction which is 10 feet wide and 65 long. Emergency lighting is present.To be monitored by the administrator. Corrected 5/24/2011	05/24/2011

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	lighting under battery power or emergency generator powered illumination. Based on interview on 4/18/11 at 11:41 p.m. with the Maintenance Supervisor it was confirmed the exit discharge for southeast hall did not adequate emergency exterior lighting available to illuminate the path of travel to a public way. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 4 smoke compartments was provided with emergency powered illumination. LSC 7-9.2 requires emergency lighting shall be provided for not less than 1 1/2 hours arranged to provide not less than an average of 1 foot candle,and not less than 0.1 foot candles, measured along the path of egress at floor level. This deficient practice could affect 9 residents from northeast and northwest halls evacuating the facility through Main hall as well as visitors and staff. Findings include: Based on observation on 04/18/11 at 1:39 p.m. with the Maintenance Supervisor, the exit corridor on Main hall next to the beauty shop had a battery powered light which when tested did not illuminate. Based on interview on 04/18/11 at 1:41			

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	p.m. with the Maintenance Supervisor it was confirmed the battery powered emergency light on Main hall did not illuminate when tested. 3.1-19(b)			
K0047 SS=E	Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to provide NO EXIT signs for two of two sets of doors which appear to be an exit, but are not. LSC 7.10.8.1 requires that any door that is neither an exit nor a way of exit access, but may be mistaken for an exit shall be identified by a sign which reads NO EXIT. This deficient practice could affect 7 residents observed in the Dining room as well as visitors and staff on Main hall. Findings include: Based on observation on 04/18/11 at 12:45 p.m., the two sets of doors on upper and lower dining room which lead into an enclosed courtyard appear to be exits but are not, are not provided with a sign saying NO EXIT. Based on interview on 04/18/11 at 12:48 p.m. with the Maintenance Supervisor it was acknowledged the set of door on upper dining room and set of doors on lower	K0047	The corrective action accomplished for this deficiency is that "Not An Exit" signs were put in place on 5/11/11 at both sets of doors by the maintenance department.Corrective action to be monitored by administrator.	05/11/2011

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	dining room which lead into an enclosed courtyard and appear to be exits but are not, are not provided with signs saying NO EXIT. 3.1-19(b)			
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to insure fire drills included the transmission of a fire alarm signal in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 of 4 quarters. LSC 19.7.1.2 requires that fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on review of Fire Drill Reports on 04/18/11 with Records personnel, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00	K0050	The corrective action accomplished for this deficiency is that all future fire drills will include notations that the alarm was activated.Corrective action to be monitored by the inservice director.	05/11/2011

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	p.m. for the past twelve months from 03/10 to 03/11, did not indicate the fire alarm system had been activated. Based on interview on 04/18/11 it was acknowledged by Records personnel none of the fire drill reports indicate the alarm had been activated. 3.1-19(b) 3.1-51(c)			
K0051 SS=F	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 1. Based on observation and interview, the facility failed to properly test and maintain 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 3-8.1 allows fire alarm system components to share control equipment or operate as stand alone systems, but in any	K0051	(1) The alarm system and components ARE as required in NFPA 72. The full system, when activiated by any interruption or by power failure, is monitored by Central Monitor Services @ 1-317-543-1300, who in turn notify the facility and local fire department of any trouble.(2)	06/03/2011

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	case, they shall be arranged to function as a single system. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. NFPA 72, 5-5.3.2.1.6.1 requires the following: A DACT (Digital Alarm Communicator Transmitter) shall employ one of the following combinations of transmission channels: (1) Two telephone lines (numbers) (2) One telephone line (number) and one cellular telephone connection (3) One telephone line (number) and a one-way radio system (4) One telephone line (number) equipped with a derived local channel (5) One telephone line (number) and a one-way private radio alarm system (6) One telephone line (number) and a private microwave radio system (7) One telephone line (number) and a two-way RF multiplex system (8) A single integrated services digital network (ISDN) telephone line using a terminal adapter specifically listed for supervising station fire alarm service, where the path between the transmitter and the switched telephone network serving central office is monitored for integrity so that the occurrence of an		The green shrub was removed on 5-6-11 and housekeeping will monitor to make sure alarm pull station is not blocked again.(3) Smoke detector and air handlers have been in place for 30 years as approved by codes. There have been NO changes or modifications. Smoke detectors are 3 feet from air return. To be monitored by administrator.6/6/11 Addendum: Trouble signal announciator was installed at the West nursing station on June 3, 2011, by Integrated Electronics of Greenfield, Indiana. The corrective action to be monitored by the nurses at the West nursing station and the 24-hour alarm service. Corrected 6/3/2011.	

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	adverse condition in the path shall be annunciated at the supervising station within 200 seconds. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation on 04/18/11 during the alarm test from 11:30 a.m. to 12:00 p.m. with the Maintenance Supervisor, the DACT next to the fire alarm control panel (FACP) was placed in trouble from phone line failure. There was a local audio trouble signal initiated in the storage room on service hall short by the DACT, however when the door was closed the alarm and visual signal could not be heard or seen. Based on interview on 04/18/11 at 12:00 p.m. with the Maintenance Supervisor it was acknowledged the trouble signal initiated by the DACT was unlikely to be heard or seen when the door was closed. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 12 manual fire alarm boxes were readily accessible. NFPA 72, The National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes shall be distributed throughout the protected area so that they are			

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	unobstructed, readily accessible, and located in the path of exit from the area. This deficient practice affects staff, visitors and 25 residents on the 100 hall. Findings include: Based on observation on 04/18/11 at 12:15 p.m. with the Maintenance Supervisor, the manual fire alarm pull station on south hall was blocked by a four and one half foot tall green shrub. Based on interview on 04/18/11 at 12:17 p.m. with the Maintenance Supervisor it was acknowledged the pull station on south hall would be difficult to find with a shrub hiding its location. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 25 smoke detectors was installed in a location which would allow the smoke detector to function to its fullest capability. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 9 residents on southeast and southwest halls as well as visitors and staff. Findings include:			

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	Based on observation on 04/18/11 at 11:18 a.m. with the Maintenance Supervisor, there was one smoke detector installed within two feet from an air supply next to station II nursing station on Main hall. Based on interview on 04/18/11 at 11:19 a.m., it was acknowledged by the Maintenance Supervisor the aforementioned smoke detector was installed within two feet from an air supply duct in the ceiling which would interfere with the smoke detector's ability to detect smoke to its fullest capability.			
K0056 SS=E	3.1-19(b) If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure the sprinkler system was installed in accordance with the requirements of NFPA 101, 2000 Edition, Sections 19.3.5 and 9.7. NFPA	K0056	The space heater was removed on 4-18-11 and a new permanent heater was installed on 5-12-11. Correction to be monitored by the maintenance department.	05/12/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	13, 1999 Edition, Section 4-2.5.2 states valve rooms shall be lighted and heated. The source of heat shall be of a permanently installed type. This deficient practice could affect all residents, staff or visitors. Findings include: Based on observation on 04/18/11 at 2:01 p.m. with the Maintenance Supervisor, the sprinkler riser room located at the south end of the west wing was provided with a permanently installed heater but did not work. There was an unplugged portable space heater on the floor of the sprinkler room which according to the Maintenance Supervisor was used to heat the sprinkler room. Based on interview on 04/18/11 at 2:03 p.m. it was acknowledged by the Maintenance Supervisor in lieu of the permanently mounted heater which did not work, a portable space heater was installed. 3.1-19(b)			
K0062 SS=F	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on record review and interview, the facility failed to ensure 1 of 1 dry automatic sprinkler piping systems was inspected every five years as required by	K0062	(1) Internal Pipe Inspection was started on 3-31-11 and completed on 5-15-22. Work was performed by P.I.P.E.,Inc. of Greenwood,	05/15/2011

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	15E281	A. BUILDING 01 B. WING	04/18/2011

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	NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.1. This deficient practice affects all occupants. Findings include: Based on review of Sprinkler system test reports on 04/18/11 at 12:32 p.m. with the facility Records keeper, it was noted an internal inspection of the sprinkler system pipes had not been done. Based on interview on 04/18/11 at 12:34 p.m. with the facility Records keeper no documentation could be obtained to verify an internal sprinkler pipe inspection had been done in the last five years. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler systems in accordance with LSC 9.7. NFPA 25, 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes and a minimum of two sprinklers of each type and temperature rating shall also be provided. This deficient practice could affect all staff, visitors and clients. Findings include:		Indiana. Work was monitored by administrator.(2) 6 spare sprinklers were located in the sprinkler room in a red metal box located on a wall. Corrective action will be done by maintenance supervisor monitoring weekly for correct number of spare sprinklers.	

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	Based on observation of the Sprinkler system's spare sprinkler box on 04/18/11 at 11:55 a.m. with the Maintenance Supervisor, there was only one extra sprinkler head provided in the sprinkler box for the upright 200 degree sprinkler heads used in the attic. Based on interview on 04/18/11 at 11:59 a.m. with the Maintenance Supervisor it was acknowledged only one extra sprinkler head was provided for the upright 200 degree sprinkler head used in the attic. 3.1-19(b)			
K0066 SS=E	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the	K0066	Self-closing cover devices (2)	05/18/2011

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	facility failed to ensure 1 of 1 areas where smoking was permitted was provided with a metal container with a self-closing cover into which cigarette butts could be extinguished. This deficient practice could affect 7 residents observed in the Dining room as well as visitors and staff near the upper Dining room smoking area outside Main hall. Findings include: Based on observation on 04/18/11 at 1:01 p.m. with the Maintenance Supervisor, the Employee lounge smoking area outside the upper Dining room on Main hall, was not provided with a metal container with self closing cover into which cigarette butts could be extinguished. Based on interview on 04/18/11 at 1:02 p.m. it was acknowledged by the Maintenance Supervisor metal ash trays with self closing lids were not provided for the designated smoking area outside the upper Dining room on Main hall. 3.1-19(b)		were ordered and will be in place by 5-18-11. Administrator to monitor corrective action.	
K0067 SS=E	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observation and interview, the facility failed to ensure 19 of 47 rooms were not using the corridor as a portion of	K0067	See waiver request dated 5-16-2011. (To be faxed)	05/16/2011

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	a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect any residents in rooms 101 through 112 including visitors and staff in the facility if the modifications had not been made. Findings include: Based on observations on 04/18/11 during a tour of the facility between 11:00 a.m. to 3:14 p.m. with the Maintenance Supervisor, resident rooms 101 through 112 were using the egress corridors as a supply air system. Based on interview on 04/18/11 concurrent with the observations with the Maintenance Supervisor, it was confirmed the return air was exhausted in the aforementioned resident rooms and the corridor was used as a supply, however, the HVAC system was modified so actuation of the fire alarm system would shut down air supply fans in ventilation ducts. Additionally, smoke detectors were installed in the ventilation ductwork which shut off air supply once the fire alarm system is activated. Finally,			

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	the HVAC ducts did not penetrate any fire or smoke barrier walls, eliminating the need for the installation of smoke dampers to prevent the transfer of smoke from one smoke compartment to another. 3.1-19(b)			
K0069 SS=E	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to install and maintain cooking facilities in accordance with the requirements of NFPA 96, 1998 Edition, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Section 3-1 states listed grease filters, baffles, or other approved grease removal devices for use with commercial cooking equipment shall be provided. Listed grease filters shall be tested in accordance with UL 1046, Grease Filters for Exhaust Ducts. Section 8-1.2 states filter-equipped exhaust systems shall not be operated with filters removed. This deficient practice could affect any resident, staff and/or visitors in the vicinity of the kitchen. Findings include: Based on observation on 04/18/11 at 1:28 p.m. with the Maintenance Supervisor the kitchen range hood system lacked any filters. Based on interview on 04/18/11	K0069	New grease filters were placed on 5-2-11. Corrective action to be monitored by maintenance department supervisor.	05/02/2011

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	concurrent with the observation with the Maintenance Supervisor it was acknowledged it was not known why there were no filters provided in the commercial kitchen exhaust hood. Further interview at the time of exit with Records personnel it was revealed the filters had been removed sometime within the past year for cleaning, but were never reinstalled. 3.1-19(b)			
K0130 SS=E	OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the location of 1 of 1 liquefied petroleum gas (LPG) containers was at least 5 feet away from a designated smoking area. LSC 8.4.3.1(3) requires the storage and handling of flammable liquids or gases to be in accordance with NFPA 58, 1998 Edition Liquefied Petroleum Gas Code. NFPA 58, Section 3-2.2.2 requires containers installed outside of buildings to be in accordance with Table 3-2.2.2. and Section 3-2.2.2(d) specifies the distance measured in any direction from the point of discharge of a container pressure relief valve, the vent of a fixed maximum liquid level gauge on a container, or the installed location of the filling connection of a container to any exterior source of ignition, openings into direct-vent (sealed	K0130	The gas cylinder was removed on 5-2-11. Corrective action to be monitored by maintenance supervisor.	05/02/2011

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	combustion system) appliances, or mechanical ventilation air intakes shall be in accordance with Table 3-2.2.2(d). Table 3-2.2.2(d) indicates the minimum distance between a portable LPG container replaced on a cylinder exchange basis and an exterior ignition source is 5 feet. This deficient practice could affect any resident near the smoking area including staff or visitors using the smoking area outside the facility near south patio. Findings include: Based on observation on 04/18/11 at 1:15 p.m. with the Maintenance Supervisor, the portable LPG container for the grill was within 5 feet from the designated smoking area. Based on interview on 04/18/11 concurrent with the observation it was acknowledged by the Maintenance Supervisor he was unaware the LPG container needed to be five feet away from a designated smoking area which could provide an ignition source. 3.1-19(b)			
K0147 SS=E	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 multiplug	K0147	Multiplug adapter was removed on 5-2-11. Corrective action to be monitored by supervisor.	05/02/2011

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	adapters were not used as a substitute for fixed wiring. This deficient practice could affect 2 residents in room # 108 as well as staff and visitors. Findings include: Based on observation on 04/18/11 at 12:41 p.m., with the Maintenance Supervisor, one resident television cord in room number 108 was plugged into a multiplug adapter at the foot end of the bed. Based on interview on 04/18/11 at 12:43 p.m. with the Maintenance Supervisor it was acknowledged resident room number 108 used a six outlet multiplug as a substitute for fixed wiring. 3.1-19(b)			